**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Health Care Access and Accountability

F-13046 (08/15)

**FORWARDHEALTH**

**ADJUSTMENT / RECONSIDERATION REQUEST**

**Instructions:** Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

The provider is required to maintain a copy of this form for his or her records.

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| **SECTION I — BILLING PROVIDER AND MEMBER INFORMATION** |
| Indicate appropriate program.[ ]  BadgerCare Plus / SeniorCare / Wisconsin Medicaid [ ]  ADAP [ ]  WCDP [ ]  WWWP |
| 1. Name — Billing Provider      | 2. Billing Provider’s Provider ID      |
| 3. Name — Member      | 4. Member Identification Number      |
| **SECTION II — CLAIM INFORMATION** |
| 5. Remittance Advice (RA) or X12 835 Health Care Claim Payment / Advice (835) Report Date, Check Issue Date, or Payment Date      | 6. Internal Control Number / Payer Claim Control Number      |
| [ ]  Add a new service line(s) to previously paid / allowed claim. (In Elements 7-15, enter information to be added.)[ ]  Correct detail on previously paid / allowed claim. (In Elements 7-12, enter information as it appears on the RA or 835.) |
| 7. Date(s) of ServiceFrom To  | 8. POS | 9. Procedure / NDC / Revenue Code | 10. Modifiers 1-4Mod 1 Mod 2 Mod 3 Mod 4 | 11. Billed Amount | 12. Unit Quantity | 13. Family Planning Indicator | 14. EMG | 15. Rendering Provider Number |
|       |       |    |       |    |    |    |    |       |       |       |   |       |
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| **SECTION III — ADJUSTMENT INFORMATION** |
| 16. Reason for Adjustment[ ]  Consultant review requested (include supporting documentation).[ ]  Recoup entire payment.[ ]  Other insurance — dental / pharmacy with OI-P $     .[ ]  Other insurance — professional / institutional (attach Explanation of Medical Benefits form, F-01234).[ ]  Copayment deducted in error. [ ]  Member in nursing home. [ ]  Covered days      . [ ]  Emergency.[ ]  Primary payer reconsideration.[ ]  Correct service line.[ ]  Other / comments.       |
| 17. **SIGNATURE —** Billing Provider | 18. Date Signed      |
| 19. Claim Form Attached (Optional)[ ]  Yes [ ]  No |